Last revised 4/19/02

ANMC Chronic Pain Program
General Agreement

Patient: Todd Allen Address: 5303 E 30th Anchorage AK 99504

Provider: Maria Freeman Office Address: _____

A. I have a chronic pain that has not been controlled by previous measures. It is not expected to go away soon. Therefore, I wish to improve my ability to better manage my pain by participating in the ANMC Chronic Pain Program.

B. I understand that the goals of the Chronic Pain Program are as follows:
1. Reduce my pain (the severity, frequency of flares, and duration of flares)
2. Minimize side effects from any medications that I take
3. Improve my physical and emotional functioning
4. Improve my ability to participate in my rehabilitation
5. Reduce the number of visits I may need for Outpatient and/or Emergency Department visits

C. I understand that this treatment requires me to do the following:
1. Attend 1-2 assessment meetings with my case manager or provider to evaluate my pain;
2. Attend 3-6 meetings with the assigned health educator to learn about ways to control my pain;
3. Set reasonable goals every 3-6 months to reduce my pain;
4. Follow the recommendations of my providers to participate in additional services that I would benefit from (such as active exercises, Mental Health).

D. I may also wish to improve my pain with opioid medication. If I take opioids, I will sign the "Agreement for Long-term Use of Pain Medications."

E. I agree to the following limits:
1. I will maintain regular, active participation by coming to all scheduled appointments on time
2. Once I sign a treatment plan, I will keep all agreements that are needed to reach my treatment goals
3. For many people living with chronic pain, involvement and support by family and friends in a treatment plan is critical for success. Your provider or case manager may want to contact the family members or friends listed below to see how they can help you in meeting your chronic pain program treatment goals. You will be notified before your provider or case manager contats them.

F. My provider or case mananger may talk to these family members, friends or people I work with to help check my progress:

Individuals my Provider May Contact For Information on My Condition

	Name	Address		Phone	Relation
1a1	Myra Allen	Box 1834 Cordova AK	1a2	907 424 3054	Mother
1b1	Kim Allen	5303 E. 30th Anch.	1b2	337-8895	Wife
1c1	Lloyd Kompkoff	Valdez	1c2	835-3223	Friend

(Patient ID Sticker Here)

2. Patient Signature and Date Todd Allen 12-12-02

Provider Signature and Date _____

Last revised 4/29/02

ANMC Chronic Pain Program
Patient Contact Information

Patient: Todd Allen

Provider: _____

Case Manager: Sarah Carter

Contact Name: Sarah Carter

The patient listed above is participating in the Chronic Pain Program at the Family Medicine Clinic at the Alaska Native Medical Center. The patient has listed you as an individual that the provider listed above or their Case Manager may call and talk with about the progress of the patient.

The Provider or Case Manager will not disclose any specific medical information about the patient. The Provider or Case Manager will ask questions related to the patient's progress with the Chronic Pain Program.

Todd Allen _____ 12-12-02

Patient Signature Date

_____ _____

Provider Signature Date